

# MISSOURI DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-043667

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 274

Primary Registration District No. 2062

Registrar's No. 438

FILED DEC 7 1962

1. PLACE OF DEATH a. COUNTY <b>Pettis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Pettis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Sedalia</b>		c. CITY OR TOWN <b>Sedalia</b>	
Length of stay in b <b>10 years</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Sedalia Rest Home</b>		d. STREET ADDRESS (If outside, give location) <b>1406 East 13th</b>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MYRTLE</b> Middle <b>RENNO</b> Last <b>RENNO</b>		4. DATE OF DEATH <b>December 2, 1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4/27/83</b>
9. AGE (last birthday) <b>79</b>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (City and state or country) <b>Cooper County, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>John Moon</b>		13b. MOTHER'S MAIDEN NAME <b>Memory Howard</b>	
14. NAME OF HUSBAND OR WIFE <b>William C. Renno</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Walter Renno, Concordia, Mo.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Parkinson's Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>-</b> DUE TO (c) <b>-</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>-</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>-</b>	
20c. TIME OF INJURY Hour <b>-</b> a.m. <b>-</b> p.m. <b>-</b> Month, Day, Year <b>-</b>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>-</b>	20f. CITY, TOWN, OR LOCATION <b>-</b>	COUNTY <b>-</b> STATE <b>-</b>
21. I attended the deceased from <b>1958</b> to <b>1962</b> and last saw her alive on <b>Dec 1, 1962</b> Death occurred at <b>4.30 p.m.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Describe or title) <b>David L. Edwards M.D.</b>		22b. ADDRESS <b>Sedalia Mo</b>	
22c. DATE SIGNED <b>12/3/62</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12/5/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Crown Hill</b>	23d. LOCATION (City, town, or county) (State) <b>Sedalia, Mo.</b>
24. FUNERAL DIRECTOR <b>Francis E. Goring</b>	ADDRESS <b>Sedalia, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>Dec. 5, 1962</b>	26. REGISTRAR'S SIGNATURE <b>Frances Shelby</b>

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

INSTEAD OF

DATE AMENDED

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

DOCUMENT

VS 300  
Rev. 4/59

6808

20808

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9350X

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*P. E. Baker*

Licensed Embalmer No. 2419

P. O. Address Sedalia Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

- If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.